UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

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UNITED STATES,

Plaintiff,

-v- 5:21-CR-124

BETHANN WALLACE,

Defendant.

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VIDEO COMPETENCY HEARING TRANSCRIPT
BEFORE THE HONORABLE THÉRÈSE WILEY DANCKS
April 6, 2022
100 South Clinton Street, Syracuse, New York

For the Plaintiff:
(Appearance by video)

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I N D E X O F T E S T I M O N Y

(The Court and all parties present by video. Time noted: 11:14 a.m.)

THE COURTROOM DEPUTY: United States of America versus Bethann Wallace, case 21-CR-124.

Counsel, state your appearances.

MR. ELDRIDGE: Good morning, your Honor. Sean Eldridge for the United States.

THE COURT: Good morning, Mr. Eldridge.

MR. LAROSE: And good morning, Stuart LaRose appearing for the defendant, Bethann Wallace.

THE COURT: All right. Good afternoon, Mr. LaRose.

And we've got Ms. Wallace on the video, too. Good morning, Ms. Wallace.

THE DEFENDANT: Good morning.

THE COURT: All right. So we are here because I have the government's motion to have a hearing under *Sell v. United States,* that's 539 U.S. 166, it's a 2003 case, for the purpose of determining whether or not you should the medicated, Ms. Wallace, for the purpose of restoring your mental competency to assist in defending yourself with regard to the charges here and to stand trial in this action.

And we're doing it by video because everybody is in lots of different places. You're in Texas, Mr. Eldridge is in Rochester, we're in Syracuse, and other folks are -- the witnesses, I think, are down in Texas, too.

All right. So do you understand what the hearing is about, Ms. Wallace?

THE DEFENDANT: I understand, Judge Dancks. And if I could take a minute, please. I'm refusing because there's no actual charges and you know it and I know it, and I don't appreciate psychiatry and psychology trying to tell me that I'm delusional because there's no actual charges because he's not a congressman, so it doesn't matter if I called his phone. And that's really all I have to say to you. I probably should've told you that in Syracuse but I didn't.

THE COURT: Okay. Well, we're here, you know, and you've been given notice of the hearing and you're entitled to be here, you know, for this hearing, you know, because -- and you're represented by counsel at this hearing and you have the right to testify on those issues if you wish to, you know, and confront the witnesses that the government is going to put on, too. And you're --

THE DEFENDANT: So I --

THE COURT: Hold on, hold on, hold on. I just want -- your counsel can present evidence on your behalf and cross examine the witnesses. So we're ready to go forward on that. And I understand your position that you don't think the charges -- there are any charges against you, but in fact there are. I understand your position in that regard, but -- so we're ready to go forward with this hearing now and you should stay

here and attend this hearing, do you understand?

THE DEFENDANT: So what happens if I don't? I'm not staying -- attending a hearing that I think is bogus, so I'm not staying.

THE COURT: The hearing will go forward. You have a right to be here and if you leave, then you're waiving your right to be here, do you understand?

THE DEFENDANT: Well, I'm waiving my right to be here. I just explained to you how I feel and I'm being very polite.

THE COURT: And I understand how you feel, but you do have a right to be here and I think you should stay here.

THE DEFENDANT: I don't want to listen to their crap.

THE COURT: Okay. Well, we're going to go forward with the hearing, so --

THE DEFENDANT: All right.

THE COURT: -- if you leave, you are waiving your right to be here, do you understand that?

THE DEFENDANT: Yes, I do. I just told you that I understood that.

THE COURT: Okay. All right. We're going to go forward without you then.

(Whereupon, the defendant disconnected from the proceeding.)

THE COURT: Mr. Eldridge, would you like to make an

opening statement?

MR. ELDRIDGE: Thank you, Judge. Very, very briefly.

OPENING STATEMENT BY MR. ELDRIDGE:

MR. ELDRIDGE: As the Court already recited, we're here pursuant to the government's motion under *Sell*. Today the government is going to present two witnesses, both who are employed by the Bureau of Prisons at FMC Carswell, that's Dr. Correa and Dr. Silvas. And just to outline this very briefly, Dr. Correa is an individual who previously submitted a report to the Court recommending that the Court find Ms. Wallace not competent to proceed and she's going to testify primarily about her evaluation of the defendant and her interactions with her.

After the Court determined she was incompetent and we entered what I'll call the 120-day restoration period, Dr. Correa continued to work with Ms. Wallace and also Dr. Silvas from Carswell got involved at that point, too. For kind of layman's terms, Dr. Correa basically has, and as the testimony is going to show, the primary responsibility or burden of diagnosing the defendant in the first place, and then once a determination is made that she can't be restored to competency through what I'll call traditional means, things like talk therapy that Court is going to hear about, it essentially then becomes Dr. Silvas's responsibility to determine whether or not there are medications that could be used and that would be appropriate, that would be safe, and that would meet the other

standards under *Sell*, the second, the third, and the fourth prongs. That is, whether or not the treatment will significantly further the interests, whether the treatment is necessary to further them considering less intrusive alternatives, and whether or not the treatment is medically appropriate.

The first *Sell* factor, the important governmental interests in trying the individual, is a legal determination for the Court to make, which I assume we'll brief after the hearing and not really the subject of today's proceeding. We're focused on the second, the third, and the fourth prongs of *Sell*.

There's six exhibits the government's going to offer. We've provided those to everyone in advance since we're proceeding in this remote fashion.

And, Judge, that's a brief summary of what I anticipate presenting this morning. Thanks very much.

THE COURT: All right. And those exhibits are Docket No. -- well, the exhibit and witness lists are Docket No. 40, but, Mr. LaRose, you got copies of the exhibits, 1 through 6?

MR. LAROSE: Yes, Judge, I have them all.

THE COURT: Okay. All right. And just before I hear from you on a brief opening statement, Mr. LaRose, I just want to confirm with you, Mr. Eldridge, the maximum penalties in this case.

On Count #1, I have ten years with a $250,000 fine

and then -- these are the maximum penalties for Count #1, which is threatening a United States official, ten years maximum imprisonment, $250,000 fine, three years of supervised release, and a $100 special assessment. And then Count #2, which is threats by interstate communications, the maximum imprisonment is five years, $250,000 fine, three years of supervised release, and a $100 special assessment. Is that correct?

MR. ELDRIDGE: Yes, your Honor.

THE COURT: Okay. I just want to make sure I didn't miss anything there in terms of the maximum penalties.

All right. Then, Mr. LaRose, would you -- do you wish to make a brief opening statement?

OPENING STATEMENT BY MR. LAROSE:

MR. LAROSE: Just briefly, your Honor. And that is that, obviously, this is a complicated and default situation. With regards to, you know, what determination the Court should make, I think is largely going to be based on testimony of the witnesses today and whether or not there are alternative means that could assist Ms. Wallace rather than medicating her as she has objected to and continues to object to.

THE COURT: All right. Anything else, Mr. LaRose?

MR. LAROSE: Nothing further at this time.

THE COURT: Okay. All right. Mr. Eldridge, then, why don't you call your first witness and we'll get the witness sworn in.

MR. ELDRIDGE: Thank you, Judge.

I think if I could -- before -- just briefly, I think it's obvious to all of us since we were sitting here, but for purposes of the record, after the Court had colloquy-ed Ms. Wallace about whether she wanted to stay or not, after her last statement, I think she said something to the effect of, "I don't want to listen to this crap," and she stood up and she walked to the back door with one of the guards and they left the room and then that camera signed off from FMC Carswell.

THE COURT: Okay. Yep, you're correct there, and I appreciate it. And I had advised her that if she didn't stay, then she was waiving her right to be here and she understood that.

MR. ELDRIDGE: Thank you, your Honor.

The government's first witness who I call is Dr. Amor Correa.

THE COURTROOM DEPUTY: Dr. Correa, please raise your right hand.

(Witness sworn.)

THE COURTROOM DEPUTY: Thank you.

MR. ELDRIDGE: Judge, may I inquire?

THE COURT: Yes.

MR. ELDRIDGE: Thank you.

DIRECT EXAMINATION BY MR. ELDRIDGE:

Q. Dr. Correa, could you tell the Court where you're employed,

please?
A. Yes, I am a forensic psychologist at the Federal Medical Center at Carswell, Texas.
Q. And how long have you worked at FMC Carswell?
A. Since May of 2016.
Q. Okay. Before you started working at FMC Carswell, did you work somewhere else in the Bureau of Prisons?
A. Yes, I worked for a few years at the federal detention center at Brooklyn and I was also a predoctoral intern at the Federal Medical Center in Butner, North Carolina.
Q. Okay. And I think you said that you're currently a forensic psychologist. What was your job title when you worked at MDC Brooklyn?
A. Clinical psychologist.
Q. All right. Can you briefly tell the Court, what's the difference between a clinical psychologist and a forensic psychologist?
A. A clinical psychologist -- my degree is in clinical psychology and a clinical psychologist does testing and diagnosis, different types of evaluations, and also therapy treatment, individual therapy, group therapy, things like that.
And a forensic psychologist -- forensic psychology means any intersection between psychology and the law. And so basically a forensic evaluation is a clinical evaluation geared towards answering some sort of legal question.

Q. All right. You mentioned a little bit about schooling. Do you have before you Government's Exhibit 1?
A. Yes.
Q. All right. Is Government's Exhibit 1 a true and accurate copy of your curriculum vitae, which I'll call a CV?
A. Yes.
Q. And did you prepare this document and then provide it to me before our proceedings here today?
A. I did.
MR. ELDRIDGE: Judge, just for purposes of the hearing, I'll offer Exhibit 1.
THE COURT: All right. Mr. LaRose, any objection?
MR. LAROSE: No, objection.
THE COURT: All right. Exhibit 1 is admitted.
Q. Dr. Correa, I'm not going to go through all of your CV, but just briefly, can you tell the Court the highest degree that you received and when you received that?
A. I have a Ph.D. in clinical psychology, received in August of 2013.
Q. Okay. And am I correct that that is shortly before you started working as a clinical psychologist at MDC Brooklyn?
A. Yes.
Q. Okay. Dr. Correa, how is a psychologist different than a psychiatrist?
A. Psychology, we do psychological testing for the purposes of

coming up with a diagnosis. We also do mental health therapy, which is what you referred to as talk therapy. It's also called psychotherapy. It's basically one-on-one or group interventions that don't require medication.

A psychiatrist has gone to medical school and so they're trained in the biological aspects of mental health and they're the ones that are trained and have the background for prescribing medications and knowing which combinations might work for the person, and that's not my role as a psychologist.

Q. All right. So as a psychologist you have a Ph.D., but not an M.D., fair statement?

A. Yes.

Q. Okay. Do -- do you work with psychiatrists at FMC Carswell?

A. Yes.

Q. How do the psychologists and psychiatrists generally work together at FMC Carswell?

A. We have a mental health treatment team that oversees all of our patients on the various mental health units that we have here at Carswell. And the treatment team involves psychologists, social workers, and various other disciplines, including psychology. And so we'll meet regularly to talk about the patients and any needs that they might have. And so it's a collaborative effort with all those disciplines.

Q. When an individual first comes into the mental health unit

at FMC Carswell, do they immediately meet with a psychiatrist or a psychologist? How does that kind of intake process generally work?

A. They always are met -- the first moment they arrive, they're screened by psychology. And if they're here for a forensic evaluation, they will meet either that week or the next week by -- they'll meet with their entire treatment team. And the psychiatrist is typically present at that treatment team meeting and that's their -- usually their first interaction with psychiatry and the -- all of the psychologists that work on that unit.

Q. Okay. In your time as a psychologist, can you estimate how many people you have evaluated for mental health conditions?

A. Specifically for forensic evaluations, more than 200. But general clinical, I mean, I've been doing general clinical evaluations since 2006.

Q. So I take it that number would be even greater than the over 200 forensic evaluations you've done?

A. Yes.

Q. Is it fair to say that the -- a forensic evaluation is what you conducted with Ms. Wallace in this case and that we're going to be talking about this morning?

A. Yes.

Q. Okay. Dr. Correa, have you testified before in federal courts as an expert in psychology?

A. Yes.
Q. Can you estimate how many times -- let me ask you this first, pardon me: Have you testified before as an expert in psychology at federal court competency hearings before?
A. Yes.
Q. Can you estimate how many times you've done that?
A. For competency specifically, let's say I've testified as an expert about 30 times. I would say that 20 of those, at least, were competency hearings.
Q. Okay. And what about the same question regarding *Sell* hearings, have you testified before as an expert in *Sell* hearings in Federal Court?
A. Yes.
Q. Can you estimate how many times you've done that?
A. About four times.
Q. Okay. I want to shift gears and talk specifically now about your interactions here.
Are you familiar with Bethann Marie Wallace?
A. Yes.
Q. All right. And when I refer to Ms. Wallace, are we talking about the individual who was on the screen at the beginning of these proceedings and told the judge that she didn't want to participate in these hearings today? Is that the person that we're talking about?
A. Yes, that's her.

Q. Okay. How did you come to be involved or in contact with Ms. Wallace at FMC Carswell?
A. She was assigned on my caseload as a person that I was going to do a forensic evaluation for and I met her as soon as she arrived at our receiving and discharge department here at Carswell.
Q. Okay. And did you ultimately conduct a court ordered evaluation of Ms. Wallace to determine if she was competent to proceed in these federal court proceedings and to assist in her defense?
A. Yes.
Q. Did that take place at FMC Carswell?
A. Yes.
Q. Have you had any contact with Ms. Wallace outside of FMC Carswell?
A. No.
Q. In connection with that court ordered evaluation that you conducted, did you prepare a report that details your findings and the work that you did to determine Ms. Wallace's competency?
A. Yes.
Q. All right. If you could take a look at Government's Exhibit 2, do you recognize what Government's Exhibit 2 is?
A. I do.
Q. What is Government's Exhibit 2?
A. It is the first report that I wrote regarding Ms. Wallace's

competency.
Q. Okay. And is your report itself dated July 16th with a cover transmittal letter from the warden dated July 22nd of 2021?
A. Yes.
Q. All right. Your report dated July 16th, does that consist of eight pages?
A. Let me verify. Yes, it does.
Q. All right. Did you write this report?
A. I did.
Q. Is that your signature that we see on page eight of the report?
A. Yes.
Q. And is this a true and accurate copy of your competency evaluation report that you completed and transmitted to the Court in these proceedings?
A. Yes.
MR. ELDRIDGE: Judge, I'd offer Government's Exhibit 2 for purposes of this hearing.
THE COURT: Mr. LaRose, any objection?
MR. LAROSE: No objection, your Honor.
THE COURT: All right. Exhibit 2 is admitted then.
Q. Dr. Correa, before you generated your July 16, 2021, report, can you estimate how many times you interacted with Ms. Wallace?

A. For formal interviews and testing, two or three times. And I saw her in her initial arrival at the R&D department. I saw her at her treatment teams meetings which happened every 30 days. So maybe once or twice during treatment meetings during the initial evaluation and also informally I would see her in the hallway whenever I was on the housing unit for those daily meetings.

Q. Okay. Fair to say you've had a significant amount of contact with Ms. Wallace before you completed your July 16, 2021, evaluation and report?

A. Yes.

Q. Did you review any documents or reports before you generated your July 16, 2021, report?

A. I did.

Q. All right. And I don't want to go through them all, but are those summarized at the bottom of page one of your report under the section Review of Records?

A. Yes, they are.

Q. And just briefly, why do you review records before you meet with Ms. Wallace to start your evaluation?

A. It's important for me to know a defendant's history so that I'd know what diagnostic questions to ask, if there are any pre-existing mental health conditions, if there's anything mental health-related that they might have said in those records. So, for example, Ms. Wallace wrote several letters, is

there anything mental health-related contained in those letters. That's the reason that I want to have that background before I start meeting with the person.

Q. Okay. You mentioned tests. Did you conduct any psychological tests with Ms. Wallace as part of your evaluation?

A. I did.

Q. What was the first test that you conducted with her? What is that test called?

A. The personality assessment inventory, the PAI.

Q. All right. And what is that test and what is its purpose?

A. It's a general test of mental health symptoms and personality traits. It also has validity scales which indicate whether or not a person is basically being honest or paying attention and taking the test seriously so you can sort of gauge if a person is overplaying their symptoms or minimizing their symptoms or just flat out not really paying attention to the test. And so it's a good way to check the validity of the person's self-report of their symptoms in situations.

Q. And is the PAI test a test that is generally used and relied upon by psychologists?

A. Yes.

Q. And specifically, is it a report -- excuse me, a test that you used and relied upon as part of your competency evaluation of Ms. Wallace?

A. Yes.

Q. Let's talk about the next test you conducted. What is that test and briefly how does it work and what is it geared to help you learn?

A. So the Evaluation of Competency to Stand Trial-Revised, or the ECST-R, is a specific competency test and it's geared towards identifying the three prongs of the *Dusky* standard, so a person's ability to consult with counsel, their rational and factual understanding of the proceedings, and it also has validity scales, which would indicate if the person is overplaying their deficits or underplaying, answering in a way that's defensive or evasive.

Q. You said understanding of the courtroom proceedings. Is that --

A. Mm-hmm.

Q. -- a conclusion you reached that is summarized starting on the bottom of page four of your report, Government Exhibit 2?

A. Yes.

Q. And is it fair to summarize some of the questions that you would be discussing with Ms. Wallace under this test as things like what is the judge's role in the proceeding or what does a prosecutor do or what does a defense lawyer do or what does the jury do? Is it those kind of general questions about the legal system that you're asking as part of the ECST-R?

A. That's part of one of the three prongs that the ECST-R does address.

Q. And did you in fact ask those types of questions to Ms. Wallace?
A. Yes.
Q. How were her responses to those questions? How would you characterize them?
A. So factually, when she was not talking about her specific case, she had a very good understanding of general courtroom procedures.
Q. Okay. So, for example, she understood what the roles of the judge, the jury, the prosecutor, and her defense lawyer were as a general matter, is that a fair statement?
A. Yes.
Q. All right. You started to say except for when she talked about her case. Let's talk about that.
When you talked to Ms. Wallace specifically about this criminal prosecution against her, did anything change?
A. Yes, that's where her responses --
Q. How so?
A. That's where her responses to the questions stopped being accurate and reality-based. She exhibited several delusional thoughts when she was talking about her specific court situation and all of the people involved in her legal case.
Q. All right. And are those laid out in pages five and six of your report?
A. Yes.

Q. All right. I'm not going to go through all of them, but could you give the Court an example or two of what you mean when you say she exhibited delusional statements or thoughts with regard to her particular case?

A. Yes. So first of all, a delusional thought is something that is fixed and not based in reality and also resistant to any kind of evidence to the contrary. So the person rigidly believes those things to be true when they're not. And so one of the most concerning things for Ms. Wallace's competency is that she thinks her -- for example, she thinks her defense attorney is biased against her because she was present when this attorney supposedly was arrested for a drug deal and has a vendetta against Ms. Wallace for being involved in his indictment. She also has delusional thoughts about her judge, believing that her judge has been against her since she was a child because of some argument that the judge had with her father.

Q. Did she also exhibit similar delusional statements and beliefs with regard to both myself, the prosecutor in this case, as well as to Congressman John Katko, the victim of the threat in this case?

A. Yes.

Q. Okay. And I'm not going to go through those, but those are detailed, I think, on page five of your report, is that correct?

A. Yes.

Q. Is the ECST-R a test that is generally relied upon by psychologists to aide in determining the competency of an individual?

A. Yes.

Q. And is it a test that you relied on specifically to determine whether or not Ms. Wallace is competent in this proceeding?

A. Yes.

Q. Dr. Correa, let me ask you this: Based on the PAI and the ECST-R themselves, could you generally diagnose someone just by giving them those two tests?

A. Not by testing alone. I also rely on --

Q. Yeah, why -- yeah, why is that? If you could explain that, please.

A. You need a fuller picture than what just a couple of tests can give you.

Q. And is that why, as you, I think, described to the Court previously, you spend time with her in different settings, in group settings, talking to her in the hallways that you testified about before? Are those important factors to you in ultimately making your determination?

A. Yes, those behavioral observations in a variety of different types of contexts. And, also, it's important to know the records that have been provided and also consult with other mental health professionals that have different types of

interactions with Ms. Wallace than I might have. And so all of those combined result in the final diagnosis and issues related to the determination of competency.

Q. You said something about observations you made of Ms. Wallace. I want to talk about that for a minute.

A. Mm-hmm.

Q. When you interacted with her, was her demeanor generally appropriate?

A. Yes.

Q. Was she generally easy to talk to?

A. Yes.

Q. How would you characterize your interactions with her aside from when you were talking about the specific facts of this prosecution?

A. Outside of talking about things related to her case, Ms. Wallace was pleasant, she was active, she had a lot of hobbies on the unit, she interacted appropriately with all of her peers on the housing unit, she exercised, she was jovial, polite, and really a very well behaved person to have on the housing unit. She created no problems at all, which is in direct contrast to when she starts talking about her case. She behaved much more -- in a much more curt manner which would be analogous to how she behaved in court today.

Q. I was going to ask you about that. In terms of how she behaved at the beginning of the court proceeding when we were

talking about her specific case, is that similar or different than how she would interact with you when you were talking about the specifics of this court case?

A. So when it came to talking about the specifics of her court case, it doesn't matter if it was me bringing it up to her or somebody else on the housing unit or the treatment team, she would behave the same way.

Q. Okay. And just -- I want to make sure I understand and that the record is clear, when you discussed with Ms. Wallace general legal matters, what does the Judge do, what does the jury do, how would you characterize those interactions with her?

A. In general, she was not agitated, she was not frustrated, she was not indignant, she gave full answers, and she gave correct answers to all of those -- essentially, you know, test questions gauging her knowledge at a general level.

Q. All right. And then on the other side of the coin, when you talked to her specifically about the facts of this case or the individuals involved in this case, Congressman Katko, Mr. LaRose, her defense attorney, Judge Dancks, myself, the prosecutor, how would you characterize those interactions?

A. She was very angry, very defensive, and rigidly adhering to her delusional beliefs about all the parties involved.

Q. All right. You said her delusional beliefs. At the beginning of the proceeding, did you hear Ms. Wallace make statements to the effect of that there are no actual charges and

that Mr. Katko is not an actual congressman? Did you hear her say those things?

A. Yes.

Q. Would you consider those to be delusional statements?

A. Yes.

Q. Are those consistent with the delusional statements you've been describing before and that are outlined in your report at pages five and six?

A. Yes.

Q. Why are those delusional statements important to you as a treating psychologist?

A. First and foremost, it's important for her diagnosis. That being said, it's not necessarily -- okay. I'll backtrack a little bit.

It's important for her diagnosis, but it's also important for her competency because these delusions directly relate to her understanding of the court proceedings against her.

Q. In terms of those delusions, would you consider those to be significant or textbook or some other descriptor examples of any particular disease or disorder?

A. I diagnosed Ms. Wallace with delusional disorder.

Q. Okay. So let's talk about that. What is delusional disorder?

A. Okay. So delusional disorder is part of what we call the psychotic disorders. And so some other disorders that fall into

that category are schizophrenia, where a person will have hallucinations and delusions. But for Ms. Wallace, she was so -- she was not experiencing any hallucinations, she never has, and she also didn't exhibit any of the functional difficulties that people with a more severe diagnosis like schizophrenia do.

Like I said, she had a lot of hobbies on the unit, she didn't need assistance with anything, and so unless you were talking to her about her delusions, she seemed like a very perfectly functional person. And so that level of ability to function day-to-day is what puts her in the delusional disorder category as opposed to something more severe. So her only predominant symptoms were these delusions.

Q. Is delusional disorder a diagnosis that you have dealt with before in your time as a psychologist?

A. Yes.

Q. Is it a common diagnosis or condition that you've dealt with in your experience as a psychologist?

A. Yes.

Q. Dr. Correa, in your report at the bottom of page six, you reference diagnosing Ms. Wallace with delusional disorder persecutory type. So I want to talk about that for a minute.

First, is that a diagnosis that's recognized in the DSM-5?

A. Yes.

Q. Okay. What do you mean -- we talked a little bit about

delusional disorder.

What do you mean when you say persecutory type?

A. That's a classification of the type of delusions that are involved for the person. And so persecutory type encompasses delusions of being somehow plotted against or persecuted or conspired against. And so the bulk of Ms. Wallace's delusions are of that nature, people are out to get her.

Q. Okay. Persecutory delusions, is that something that you regularly deal with in your practice as a psychologist?

A. Yes.

Q. I want to talk to you a minute about -- for a minute about your diagnosis. So after you diagnosed -- let's stop there. Let me ask you a different question. I apologize.

How did you come to your diagnosis of Ms. Wallace as having delusional disorder persecutory type?

A. After reviewing all of the previous records and all of the test results, also my interactions with her and what she tells me during interviews, checking with the mental health nurses to see her level of functioning. And so all of that plays in because that's -- the level of functioning piece is pretty crucial to differentiating delusional disorder from some of the other more severe, let's say, psychotic disorders where she's having hallucinations.

Q. Okay. And in diagnosing this condition, is it fair to say that you have to rely on your training and experience and

background to make this diagnosis? And what I mean by that is -- maybe asked a better way, could you give someone a blood test like you would test for high cholesterol to find out that somebody has delusional disorder? Is that possible?

A. All right, there's no one test for delusional disorder.

Q. Okay. So is it, in fact, a combination of all of the things you've been discussing here this morning, the two tests, your observations, and the findings that you've outlined in your report, Government Exhibit 2?

A. Yes.

Q. Are the things that you talked about, Ms. Wallace's correct answers and polite demeanor when talking about the judicial system in general, and then her delusional statements and change of demeanor when talking about this specific case consistent with delusional disorder persecutory type?

A. Yes.

Q. How so?

A. So, for example, because of her delusions, the only two prongs of the *Dusky* standard that are effective for Ms. Wallace are her rational understanding. So she doesn't have a rational grasp of what's really happening in her legal case. It's all -- her understanding is all based on delusional thoughts. She has some delusions about her defense attorney and so that impacts her ability to reasonably consult with counsel in her defense.

But her factual understanding is not really impacted at all

and that's consistent with delusional disorder where she's not being distracted by hallucinations, she's able to stay organized and focused on factual things, and so that's the high level of functioning that I'm talking about when I say that, you know, she's not -- delusional disorder is very much contained to just specific delusions.

Q. All right. Dr. Correa, I think I neglected to ask you before if -- as part of your evaluation, did you ask Ms. Wallace if she had been treated by a mental health professional before?

A. Yes.

Q. And did you ask her if she had any issues with drug abuse or alcohol abuse in the past?

A. I did.

Q. And why do you ask those questions?

A. Because they could factor into the diagnosis in multiple ways.

Q. And in this case, your evaluation of Ms. Wallace, did those -- the answers to her questions factor into your diagnosis in any way?

A. Yes.

Q. How so?

A. So I ruled out the notion that any of her delusional thinking was related to her historic substance abuse, alcohol specifically. She continued to exhibit those thoughts and behaviors regardless of whether she was consuming alcohol or

not.

Q. Okay. And other than alcohol, did she discuss any substance abuse problems that she had in the past?

A. No. And her records from Helio Health also identified alcohol as the main substance of concern for them.

Q. All right. And you referenced Helio Health. Other than the Helio Health evaluation, did she describe any other mental health treatment or evaluations that took place?

A. No prior treatment, which is actually not uncommon for people with delusional disorder.

Q. Why is that?

A. Because they're functional -- they're functional outside of discussions related to their delusions. And additionally, they don't see their thoughts as delusions, so they don't refer themselves for mental health treatment.

Q. You referenced a Helio evaluation. Is it your understanding that that Helio evaluation took place as part of these proceedings and was ordered by the Court before Ms. Wallace came to FMC Carswell?

A. Yes.

Q. Okay. Dr. Correa, after you diagnosed Ms. Wallace with delusional disorder persecutory type, do you sit down and tell her, "Ms. Wallace, I've completed my evaluation, I diagnose you with this condition?"

A. Sometimes I do with certain defendants. For Ms. Wallace,

since I suspected that she would be staying at Carswell for another 120 days of restoration, I told her that it was likely that she was going to not be found competent by the judge and have to stay for the 120 days, but at that point I didn't go into detail about her diagnosis because I wanted to preserve any rapport that I had with her instead of being immediately placed in her bucket of fake government officials. And so to try to keep the rhythm going so-to-speak, I didn't go into a full explanation, but she already suspected that people thought she was delusional.

Q. Okay. You started to mention what comes next in maintaining a rapport in a 120-day period, so let's talk about that.

You find Ms. Wallace not competent, you submit your report to the Court, what is the next thing that happens in the proceedings? What is this 120-day period and what are you doing during that time?

A. Okay. So the 120-day period is a restoration to competency period, and so that's where the treatment team especially -- I mean, if someone were -- if Ms. Wallace were receptive to medications as part of her treatment, there's no reason that she couldn't have started them in the 30 days, but she adamantly did not want to have any medication. And so for the 120 days, that's when the treatment team starts seriously talking about what it would take to restore this person to competency in the

four months.

And part of that is group therapy, talk therapy, meetings with her treatment team, and discussions, if the person needs it, with the psychiatrist. And Ms. Wallace was referred for meetings with the psychiatrist.

Q. All right. So do I understand correctly that the general idea of the 120-day period is for the treatment team at FMC Carswell to try to restore Ms. Wallace to competency for these proceedings?

A. Yes.

Q. Okay. Is medication, like, the first thing that the treatment team jumps to?

A. No. And in fact, most of -- a lot of people don't need medications to be restored.

Q. All right. You started to mention some items, group therapy and talk therapy. Before we start talking about those, let's take a look at another thing, Government's Exhibit 3, if you have that in front of you.

A. Yes.

Q. Do you recognize Government's Exhibit 3?

A. I do.

Q. All right. And what is Government's Exhibit 3?

A. It is the second report I wrote regarding Ms. Wallace's competency, that would be during the 120-day restoration period.

Q. Okay. Is the report dated January 7, 2021, with a

transmittal cover letter dated January 10th of 2022?
A. Yes.
Q. All right. And, in fact, is -- that date on the top of the report, January 7, 2021, is that just a typo? That should really be 2022?
A. It should be 2022.
Q. Okay. I think you said that this report is generated during the 120-day period.
Is this report generated during the period or is this at the end of the 120-day period?
A. It's after the end of the 120 days.
Q. Okay. At the end of the document here, page five of your report, we see a signature at the bottom. Whose signature is that?
A. That's mine.
Q. All right. Is Government's Exhibit 3 a true and accurate copy of your January 7, 2022, report?
A. Yes.
MR. ELDRIDGE: Judge, I offer Government's Exhibit 3 for purposes of this hearing.
THE COURT: All right. Any objection, Mr. LaRose?
MR. LAROSE: No objection.
THE COURT: All right. Exhibit 3 is admitted.
Q. Dr. Correa, in the 120-day period, you started to mention some things that were done to try to restore Ms. Wallace to

competency. Let's talk about those for a minute.

What is group therapy or talk therapy? First, can you tell me generally what they are?

A. Yeah, so talk therapy typically -- and the way that I used it a while ago is referring to one-on-one sessions with a therapist. And so since she -- Ms. Wallace was sent here for competency restoration, the treatment goal is to restore her to competency, and so any meetings that she would've had one-on-one with a psychologist would be towards the goal of getting her restored to competency through non-medication means.

Q. All right. You -- you've accurately predicted my next question, which was: Was any medication used during this 120-day period?

A. Oh, no medication.

Q. Okay. Have you successfully restored people to competency in this 120-day period by using the things you described, group therapy and talk therapy?

A. Yes.

Q. Were you hopeful that during this 120-day period group therapy and talk therapy would be successful with Ms. Wallace to restore her to competency?

A. Well, Ms. Wallace from the very beginning exhibited very, very rigid adherence to her delusional thoughts, and that's not the best indicator of just talk therapy being successful. That being said, people can certainly have delusions and still be

competent. It matters -- the flexibility of the delusions matters. So is the person able to have some delusional thoughts but challenge them and maybe consider some more rational reality-based options, are they insightful, do they recognize themselves that they have delusions and accept that. And so those are good prognosticators for talk therapy maybe being effective enough to restore the person to competency.

Also, I mean, if their delusions had nothing to do with their legal case or their understanding of the proceedings, then they can have delusions as long as they can separate that from their case and still be competent.

Q. Okay. You said something about being insightful and --

A. Mm-hmm.

Q. -- I think you talk about Ms. Wallace's insight and her disease in her report.

What do you mean when you say that Ms. Wallace had poor insight into her condition?

A. So poor insight -- insight in general is really the ability to reflect accurately and learn about their symptoms and accept that they're a symptom. And so if somebody had insight into the fact that they had delusions, then you can work with that in traditional talk therapy and get them to challenge a little bit about the delusions and introduce more reality-based reasoning. And so if somebody has the ability to be introspective that way, they have what we call insight.

Q. Okay. Did -- was Ms. Wallace insightful at all into her delusional disorder?
A. No, she thinks that everyone who disagrees with her is -- they're actually the ones who are delusional, living in fantasy land.
Q. Okay. And, in fact, in your report, Government's Exhibit 3, do you outline some of those statements from Ms. Wallace, including -- you know, she says, "how would I take a plea bargain when there are no charges," or, "this is kind of ridiculous, don't you think, there's no charges," and referring to people in the system as being fraudulent and expressing her belief that she's going to get released but it's not going to be by your people. Are those some of the statements you're referring to?
A. Yeah. I mean, she told me that -- and she told me this about myself, that if I didn't believe her, that it was just proof that I was part of the fake Antifa government instead of the real government.
Q. Why are those statements important to you during this 120-day period?
A. It shows her rigidity and her inability to consider alternative beliefs that are non-delusional.
Q. Okay. During this 120-day period, do you try to convince her to voluntarily take antipsychotic medications?
A. Yes.

Q. Why?
A. If any member of the treatment team, myself included, the psychiatrist included, and any other psychologist or social worker or mental health nurse really feels that it's the only way to get the person restored to competency, then we'll start having those conversations with her.
Q. Is there a set time during the restoration process that you would get a psychologist -- excuse me, a psychiatrist involved in the process?
A. There's not a set time. It really depends on the person and their specific symptoms.
Q. Okay. In this case, did you get a psychiatrist involved during the 120-day period as it relates to Ms. Wallace?
A. Pretty early on during the 120 days. In fact, I told the psychiatrist during the initial 30-day period that, hey, this -- Ms. Wallace is not competent, she'll probably be someone who should be on your radar as potentially needing medication because of her rigidity as far as the delusional thoughts.
Q. And who is the psychiatrist that you're referring to here?
A. Dr. Silvas.
Q. Okay. Is Dr. Silvas also an individual who works at FMC Carswell with you and is part of the Carswell treatment team?
A. Yes.
Q. Okay. Fair to say that you got Dr. Silvas involved in Ms. Wallace's case maybe earlier than others or earlier than most

based on what you had already observed from Ms. Wallace and what you described as her rigidity about her persecutory beliefs?
A. Only involved in the sense that I informed him that Ms. Wallace should be on his radar as somebody that he might be meeting with. But that being said, I mean, we didn't push Ms. Wallace into taking medication. And so he wasn't prescribing anything because, I mean, she has the right to refuse.
Q. All right. So during this 120-day period, is it fair to say that you recommended and offered medications to her, but it was 100 percent voluntary on Ms. Wallace's behalf whether or not she wanted to take them?
A. Right.
Q. Did she in fact take any?
A. No.
Q. What, if anything, did she tell you about the medications that were proposed to her to help with her condition?
A. That she didn't need it, that she didn't have any mental illness, that it was unnecessary. And usually in those conversations she would devolve into some tangential conversation about the fraudulent charges and the fraudulent judge and all of that.
Q. And are those behaviors that Ms. Wallace is exhibiting and you're describing consistent with your diagnosis of delusional disorder persecutory type?
A. Yes.

Q. Speaking of medication, do you have any role in recommending or deciding what type of medication might be appropriate for one of your patients?
A. I mean, I have a general sense of the medications that are used for certain diagnoses, like, antidepressants are good for depression, antipsychotics are good for psychosis, so in general terms, yes, based on the diagnosis that I find a person has, but in terms of the actual medications given, that's all up to a psychiatrist.
Q. All right. So not to oversimplify this too much, but is it fair to say that as the psychologist, you're primarily performing the diagnosis of the condition and then the psychiatrist would be the person who could ultimately prescribe medication if necessary?
A. At Carswell, yeah, basically that's how it works.
Q. Okay. If a person is being treated for a mental disease or illness during this 120-day period and the staff feels that medication might be necessary, is there any type of an administrative hearing that takes place within the Bureau of Prisons?
A. Yes.
Q. And did one of those hearings take place as it relates to Ms. Wallace?
A. Yes.
Q. And, excuse me, I need to grab my other pile of exhibits.

If you could look briefly at Government's Exhibit 6, let me ask you first: Were you present at such an administrative hearing on November 17, 2021, at Carswell regarding Ms. Wallace?

A. Yes, I was.

Q. What is the purpose of that hearing?

A. The purpose of the hearing -- in general, it's an administrative hearing to see if a person either needs -- meets criteria for involuntary medication under *Harper* criteria or under *Sell* criteria. And so *Harper* is, like, an immediate danger to themselves or others or symptoms that are so severe that the person is disabled by that. For Ms. Wallace, that was never a question.

So for her hearing, this -- this administrative hearing was just for the purposes of preparation for *Sell*, so deciding if psychiatry, based on my testimony, based on others's testimonies, believed that Ms. Wallace would need medication under *Sell* to become competent.

Q. All right. So just to recap that a little bit, *Harper* is a standard that would allow the BOP to involuntarily medicate someone if it was determined after an administrative hearing that the person was either a danger to themselves or to others, is that a fair summary?

A. Yes.

Q. Okay. And that is not Ms. Wallace? Nobody is suggesting --

A. Right.
Q. -- that she is a danger to herself and that is not your opinion, is that correct?
A. Exactly. Ms. Wallace was never in that category.
Q. Okay. And, in fact, is Government's Exhibit 6 the BOP forms and summary of that hearing that took place on November 17th of 2021?
A. Could you ask that question again?
Q. Certainly.
Is Government's Exhibit 6 the BOP paperwork and summary regarding that November 17, 2021, hearing?
A. Yes, it is.
Q. And, in fact, did you testify at that hearing?
A. I did.
Q. And if we look at page -- well, in the bottom right-hand corner, it says page three of four. About two-thirds of the way down the page, do you see a subsection B that says, summary of treatment, evaluating team member statements, with your name and then a summary of your testimony?
A. Yes.
Q. Have you seen this document before you came here today?
A. Yes, I did.
Q. And is this a fair summary of your testimony from that hearing?
A. It is.

Q. I want to go back to page one of Exhibit 6 for a minute.

Do you recognize the handwriting in the top section that starts, "Ms. Cuccio?" And that's C-U-C-C-I-O.

A. Mm-hmm.

Q. Whose handwriting is that?

A. I recognize Ms. Wallace's handwriting.

MR. ELDRIDGE: Judge, for purposes of the hearing, I'd offer Government's Exhibit 6.

THE COURT: Mr. LaRose?

MR. LAROSE: No objection.

THE COURT: All right. Exhibit 6 then is admitted for purposes of this hearing.

Q. Dr. Correa, you talked a little bit about *Harper* criteria.

Do you agree with the conclusion that under the *Harper* criteria, Ms. Wallace is not a danger to herself or others?

A. I agree with that.

Q. All right. Is it further -- what is your opinion as to Ms. Wallace's competency without taking antipsychotic medications?

A. In the 120 days that Ms. Wallace was here for restoration, we tried all non-medication forms of treatment. And so those were not successful in restoring her to competency. I would anticipate if she were to be ordered for another 120 days of restoration with those same methods that the outcome would be the same, this is why I am thinking medication is really the only way to make sure she's restored to competency.

Q. In your opinion, has the medical staff at FMC Carswell exhausted the non-medicative options for restoring Ms. Wallace to competency?
A. Yes.
Q. So is it your opinion that without taking the recommended antipsychotic medications, that Ms. Wallace will remain incompetent to assist in her defense and to participate in these legal proceedings?
A. Yes.
Q. All right. Thank you very much, Doctor.
MR. ELDRIDGE: Judge, those are my questions.
THE COURT: All right. Mr. LaRose, cross exam.
MR. LAROSE: Thank you, Judge.
CROSS EXAMINATION BY MR. LAROSE:
Q. Doctor, with regards to the difference between her having delusions only regarding this case and her not having delusions or acting, I'll say, normally regarding the rest of her life, is it unusual for a patient to present with such a limited area of delusion?
A. It's not unusual with someone who only meets diagnostic criteria for delusional disorder. And so outside of the specific delusions, the person appears completely functional and really doesn't have any ramifications.
Q. Okay. And you talked about all the nonmedical treatment, and I know we've touched on the talk therapy or psychotherapy

regarding that.

What other nonmedical -- non-medicine treatment was provided to her other than the talk therapy during the 120-day restoration period?

A. So she was also enrolled in a weekly competency restoration group. And so that's an avenue where the -- a lot of defendants who are here for competency restoration meet and bounce ideas off each other. There's a facilitator who is a psychologist who runs the group. And in that forum, they focus a lot on factual understanding, but also challenging of delusions.

And in those groups, there are people with delusions who have varying degrees of insight like I talked about, and some of those individuals can reflect on their delusions and how they may be impacting their competency. And so they're encouraged to, you know, share some strategies and other defendants can pick up basically some insight based on hearing just the stories of their peers compared to an authority figure, like the facilitator or the teacher or the psychologist. And so it gets the -- it gets them thinking in a different sort of way and that's -- that's successful for some people.

Q. Okay. You continued to work with her throughout that 120-day period of attempted restoration of competency, correct?

A. Yes.

Q. Did you find any improvement with her from the time you started meeting with her up until you wrote the January 10th

report?
A. No. In fact, she became more guarded and careful about what she would say to me, especially in treatment team. In treatment team, she was less willing to talk about the delusional thought content. She would often look at me in those meetings and say, "you know what I'm talking about," as opposed to sharing what she was talking about with the rest of the people.
Q. You said that fairly early on, if I understand what you had testified to, you felt there was going to be a need for medication in her case, is that correct?
A. Yes.
Q. And do you know at what point you first made that assessment, how long after you had been working with her?
A. It was pretty close to when I was finalizing the diagnosis because that's when the real rigidity of her delusional beliefs became apparent. I, as part of my initial evaluation, tested her adherence and rigidity to the delusional thoughts and she was extremely rigid --
Q. Okay.
A. -- and had no insight.
Q. And when you wrote the report on, I think, January 10th of the -- of what had occurred during that 120-day period, at that point the 120 days was over, we're now in April, has she not received any additional counseling or, you know, assistance for

her delusional problems since that first 120-day period expired?
A. So she continues to refuse medications. She has regular check-in meetings with a psychologist, but, I mean, still, she doesn't show any insight. And when you talk to her about her delusions, she behaves similarly to how she did this morning at the beginning of the hearing.
Q. Okay. So she checks in with a team, but she's not receiving any individual or group counseling for these delusions at this time?
A. She checks in with the treatment team. She also has scheduled individual meetings with a psychologist, but, again, those are not very fruitful because she is so adhered to her delusional thoughts.
Q. And based upon what treatment has been provided to her, has every other means aside from medicine been exhausted at this point in time?
A. Yes.
Q. Okay. Thank you.
MR. LAROSE: I have no further questions.
THE COURT: All right. Any redirect?
MR. ELDRIDGE: No, thank you, your Honor.
THE COURT: All right. I just have one clarification question for the doctor.
So since the January report, she is getting some talk therapy, just so I understand?

THE WITNESS: Yeah, we do that with all of the defendants that end up having a holdover period. Somebody checks in with her from the psychology department regularly.

THE COURT: Okay. I just want to understand what you mean by checks in with her regularly.

THE WITNESS: So --

THE COURT: She actually has a talk therapy session, like on a weekly basis, or what?

THE WITNESS: So she has a talk therapy session on a monthly basis and she can use that to express any kind of concerns. I don't think Ms. Wallace specifically chooses to participate very much.

THE COURT: Okay. Does she have any group sessions since January?

THE WITNESS: She does go to social work therapy groups when they happen, but, again, those are very general and they wouldn't be specific towards her.

THE COURT: And how often does that occur, the social work?

THE WITNESS: It occurs -- it occurs sporadically, especially since COVID restrictions and quarantine and things like that. Sometimes it happened -- it's happened every week before, but sometimes there's been a three-week break, so that hasn't been consistent.

THE COURT: Okay. All right. Thank you.

All right. Anything else for this witness, I guess, Mr. Eldridge, since I asked some questions?

MR. ELDRIDGE: No, thank you, your Honor.

THE COURT: All right. Mr. LaRose, any other questions for this witness?

MR. LAROSE: No, thank you.

THE COURT: Okay. All right. Thank you, Doctor.

All right. Do you have another witness, Mr. Eldridge?

MR. ELDRIDGE: I do, Judge. May I step out for ten seconds just to grab another piece of paper that I don't have in front of me?

THE COURT: Absolutely.

MR. ELDRIDGE: Thank you very much.

THE COURT: Everybody stand and stretch.

DR. SILVAS: Your Honor, this is Dr. Silvas with a request before I'm called to testify. If we can also take a quick break for nature so that I can focus on the questions that I'm asked.

THE COURT: Absolutely. Let's -- I've got 12:27. Why don't we take ten minutes? All right?

DR. SILVAS: Thank you, your Honor.

THE COURT: Don't anybody disconnect from the meeting because there was --

MR. ELDRIDGE: I'm going to mute and stay online.

Thank you, Judge.

THE COURT: Everybody mute and shut off your camera if you want to and then we'll start back up in ten minutes. Okay? Twenty of, a little more than ten minutes. All right? Thanks.

(Court in recess. Time noted: 12:27 p.m. to 12:39 p.m.)

THE COURT: All right then. I think we're all back and let's go back on the record.

All right. We just took a brief recess and you have another witness, Mr. Eldridge? Mr. Eldridge, do you want to call your next --

MR. ELDRIDGE: I do. Thank you, your Honor.

The government calls Dr. Jose Silvas.

THE COURTROOM DEPUTY: Dr. Silvas, please raise your right hand.

(Witness sworn.)

THE COURTROOM DEPUTY: Thank you.

THE COURT: All right. You may inquire, Mr. Eldridge.

MR. ELDRIDGE: Thank you, Judge.

DIRECT EXAMINATION BY MR. ELDRIDGE:

Q. Dr. Silvas, good afternoon for me, good morning for you.

A. Good morning, sir.

Q. Could you tell the Court where you're employed and what

your current job position is?
A. I'm employed as a board certified staff psychiatrist at Federal Medical Center Carswell in Fort Worth, Texas with the Bureau of Prisons.
Q. And how long have you been a psychiatrist at FMC Carswell?
A. I have been a staff psychiatrist here for 14 years.
Q. All right. And aside from your BOP time, approximately how long have you been a psychiatrist for?
A. Forty years.
Q. All right. Dr. Silvas, do you have Government's Exhibit 4 in front of you?
A. Yes, sir, I do.
Q. What do you recognize Government's Exhibit 4 to be?
A. As the curriculum vitae for myself.
Q. Is this a document that you prepared?
A. Yes.
Q. Is it a true and accurate reflection of your CV, that is your education, your prior experience as it relates to psychology -- psychiatry?
A. Yes.
Q. Psychiatry, excuse me.
A. Psychiatry, yes, sir.
Q. Thank you.
MR. ELDRIDGE: Judge, for purposes of the hearing, I offer Exhibit 4.

THE COURT: All right. Any objections, Mr. LaRose?

MR. LAROSE: No objections.

THE COURT: All right. Exhibit 4 then is admitted.

Q. All right. Dr. Silvas, we heard previously from Dr. Correa in this proceeding about FMC Carswell.

Fair to say you work at the same facility?

A. Yes.

Q. All right. Do the psychologists and psychiatrists work together at FMC Carswell?

A. We share the responsibilities for evaluating, recommending treatment, and providing treatment in conjunction with the services and therapies provided by each of our specialties, yes, sir.

Q. And as a staff psychiatrist, how is your authority different than that of the psychologists like Dr. Correa?

A. My primary role is to provide medically approved treatment by prescribing medication for the alleviation of mental illness.

Q. Is dealing with and treating mental illness a regular part of your job as a staff psychiatrist at FMC Carswell?

A. Yes, sir, it is.

Q. Can you estimate how many people you've evaluated for mental health conditions over your 14 or almost 15 years at FMC Carswell?

A. I couldn't really give the Court even an accurate estimate -- guestimation.

Q. Is that because it's too many to count?
A. That I can agree with.
Q. Okay. Have you testified before in federal court proceedings as an expert in psychiatry?
A. Yes.
Q. Have you testified before in federal court in *Sell* hearings?
A. Yes.
Q. Can you estimate how many times you've done the latter, that is *Sell* hearings?
A. My estimate -- best recollection for *Sell* hearings in the 14 years is between 10 to 15 cases.
Q. Okay. Are you familiar with an individual by the name of Bethann Marie Wallace?
A. Yes, sir, I am.
Q. And did you see Ms. Wallace on the screen here at the beginning of the proceedings telling the Court that she refused to participate today?
A. Yes, I did.
Q. All right. And that's the person you recognized as Ms. Wallace that we're going to be focused on talking about today, fair statement?
A. It is, yes, sir.
Q. All right. Dr. Silvas, when did you first become involved in treating or caring for Ms. Wallace at Carswell?

A. When she had her first meeting with the treatment team, the multidisciplinary treatment team after her arrival at Carswell to proceed with a competency court ordered evaluation to be conducted by the psychology staff.

Q. Okay. And you were present for Dr. Correa's testimony, is that fair?

A. Yes, sir, I have been.

Q. All right. And that's the same evaluation that she referred to earlier in her testimony starting with intake and then carrying through her evaluation? Is that the general time period you're referring to?

A. It is, yes, sir.

Q. Can you estimate how many times you've interacted with Ms. Wallace during her time at FMC Carswell?

A. The specific interactions related treatment recommendations relative to this case has been twice. And then in addition to that, the monthly interactions of the treatment team and any interactions where I see her on the unit as I do my regular rounds.

Q. All right. Have all of your interactions with Ms. Wallace taken place inside FMC Carswell?

A. Yes, sir, they have.

Q. All right. Is it your understanding that Ms. Wallace was diagnosed with delusional disorder persecutory type at FMC Carswell?

A. Yes, sir.
Q. Did you make that initial diagnosis of Ms. Wallace?
A. No.
Q. Why not?
A. The manner in which forensic studies are conducted at this federal medical center has the psychologist assigned to the case responsible for making the diagnostic determination.
Q. All right. So in other words, that's Dr. Correa's job in the first instance, fair?
A. Yes, sir, it is.
Q. All right. After you received Dr. Correa's diagnosis and begin evaluating Ms. Wallace, was part of the purpose of your meeting with Ms. Wallace to confirm that you shared the same view of Dr. Correa's diagnosis?
A. For clarification, are you asking to confirm to Ms. Wallace?
Q. No, to confirm for yourself.
A. Yes.
Q. All right. And I apologize, it was kind of a wordy question. I'll do better.
Did you -- after meeting with Ms. Wallace, do you agree with Dr. Correa's assessment and diagnosis of Ms. Wallace as having persecutory -- excuse me, delusional disorder persecutory type?
A. The agreement with Dr. Correa's findings includes not only

meeting with the said inmate, but also having reviewed Dr. Correa's report findings, and also having reviewed the medical record during the time that the inmate has been detained here at Carswell. So it includes all of that information.

Q. And based on all of those, is it also your professional medical opinion --

(Whereupon, the court reporter interrupted for clarification.)

MR. ELDRIDGE: No, no, it froze on my side, too, so I apologize. I'll ask the question again.

Q. Dr. Silvas, based on all of those items, is it also your professional medical opinion that Ms. Wallace has delusional disorder persecutory type?

A. I concur that she is diagnosed with delusional disorder persecutory type, yes, sir.

Q. Okay. Was part of your interactions with Ms. Wallace for the purpose of trying to restore her to competency?

A. Yes.

Q. As part of your interactions with Ms. Wallace, did you prepare a report regarding your interactions and evaluation?

A. Yes.

Q. Dr. Silvas, if you could take a look at Exhibit 5, is that a copy of your report dated November 16th of 2021, regarding Ms. Wallace?

A. Yes.

Q. Is this a true and accurate copy of your November 16, 2021, report?

A. Yes.

Q. Did you write this report yourself?

A. I did, yes.

MR. ELDRIDGE: Judge, for purposes of the hearing, I offer Government's Exhibit 5.

THE COURT: Mr. LaRose?

MR. LAROSE: No objection, Judge.

THE COURT: All right. And this is an unsigned exhibit. That's the one I have, Mr. Eldridge, is that correct?

MR. ELDRIDGE: That's correct, Judge.

THE COURT: All right. I'll admit it. Exhibit 5 is admitted.

Q. Dr. Silvas, just for clarification, is there a copy of this report that you also physically signed?

A. Yes.

Q. Is it any different than Government's Exhibit 5, other than we don't see your handwritten signature on Exhibit 5?

A. The only difference is the signature.

Q. All right. Dr. Silvas, delusional disorder persecutory type, I want to talk about that for a couple minutes.

Is that a diagnosis that you have dealt with before?

A. Yes.

Q. How often?

A. Because my career has been primarily in institutions and treatment services for the seriously mentally ill, not necessarily offenders but also private patients in treatment service systems, it has been a frequent diagnosis that I have encountered and dealt with.

Q. Okay. Fair to say that when you are dealing with this disorder, one of your goals is to treat the condition?

A. The goal is to assist the patient in understanding that in my findings and opinion there is a diagnosable disorder and a treatable disorder so that they know their options, to consider treatment if they wish to accept it.

Q. So let's talk about treatment. How is delusional disorder treated?

A. Delusional disorder can be treated with psychological interventions, often referred to as psychotherapy, either on an individual basis or in group therapy. And then when psychiatry is involved, that's when we begin to consider the treatment of the condition with the use of approved psychiatric medication.

Q. Okay. And in Ms. Wallace's case, was that first category of treatment, psychotherapy, individual and group therapy, were those attempted in order to restore -- in order to attempt to restore Ms. Wallace to competency?

A. As Dr. Correa reflected in her testimony, the psychology department specifically -- specifically for forensic cases takes inmates through their approved process of non-medication

therapy. So when Dr. Correa informs me, and I also learn this in my participation with the treatment team, that the inmate has been registered and is participating, that's how I find out that that has been utilized.

Q. Fair to say that your involvement or level of involvement increases if the -- if the psychology department is unable to treat an individual fully with non-medication means?

A. I'm going to offer a clarification as follows: There are, on occasion, forensic cases referred to this institution that are already prescribed medication. So if they are taking psychiatric medication already from a previous psychiatrist or physician when they arrive, I immediately have the responsibility to supervise and monitor, number one, whether the inmate chooses to continue those medications and, if they choose to continue, to monitor their response during the course of the study.

Now, that's in contrast to other inmates that arrive that have not been previously treated, as is the case with Ms. Wallace.

Q. That was going to be my next question.

Is Ms. Wallace one of those individuals who was being treated with antipsychotic medications when she arrived at your facility?

A. No, sir.

Q. Okay. Regarding Ms. Wallace, in your professional medical

opinion and based on your evaluation of her, what is necessary to restore her to competence?

A. With the awareness that I mentioned that she has been given the opportunity to participate in non-medication restoration treatment from the psychology staff and with the understanding that there is now the continued consideration as to whether she can achieve restoration with the alternative treatment of psychiatric medication, then in reviewing where she has not responded to non-medication treatment, it now is my opinion that if restoration of competency is to be the goal, I don't see any less restrictive alternative that's likely to achieve that outcome unless medication is utilized.

Q. Why is that?

A. Delusional disorder, regardless of the type that is being considered, understanding that there are various types of delusional disorder, but regardless of the type, it is known to be a very difficult psychiatric condition to treat effectively. And the primary reason for that is the very cause of the problem, which is that the individual does not believe that they have any disorder and, therefore, doesn't have any ability to understand the recommendation for treatment.

Q. You said the individual doesn't have any ability to understand the treatment.

Are you referring to what Dr. Correa and I talked about during her testimony as her lack of insight? Are those the same

thing?
A. Yes, sir, I am.
Q. Okay. You said that it's your opinion that medication would be necessary to restore Ms. Wallace to competence. Let's talk about that a little bit.
What is your recommended prescribed treatment of Ms. Wallace?
A. Specifically in her case, I have recommended a scheduled antipsychotic injection that -- with the specific medication I have recommended which is Invega Sustenna, the brand name, the generic name is Paliperidone -- that an injection is necessary because she is otherwise unwilling to consider medication on a voluntary basis, which I will add I have offered to her, along with the education necessary for her to understand the option, and the purpose of considering voluntary consent for the same medication. The difference being, that with voluntary consent, it could be prescribed orally as opposed to the current involuntary recommendation for scheduled injections.
Q. All right. Let's break that down a little bit.
The medication you described was Invega, I-N-V-E-G-A, Sustenna, S-U-S-T-E-N-N-A, which goes by the generic name Paliperidone, P-A-L-I-P-E-R-I-D-O-N-E, is that right?
A. Yes, sir.
Q. All right. I'm going to refer to it as Paliperidone if that's okay.

What is Paliperidone?

A. Paliperidone is in the group of antipsychotic medications, most often referred to as second generation antipsychotics to distinguish them from the earlier medications that were utilized, which reflects upon the improvements that have been made over the course of my practice in looking for medication that is increasingly effective, but also at the same time can avoid the onset of side effects to be a problem.

Q. All right. You mentioned -- you called it a second generation antipsychotic.

Are you familiar with a medication called Risperidol [sic], R-I-S-P-E-R-I-D-O-L?

A. Yes, sir.

Q. What's Risperidol?

A. Risperdal is also a second generation antipsychotic that came on the market preceding Paliperidone. Paliperidone actually ends up being a cousin medication because it is a known metabolite that is also effective as a medication, so it became developed as a separate treatment option from Risperdal primarily because it was discovered that Paliperidone has a lower side effect profile than Risperdal.

Q. So is Risperdal a medication you considered prescribing to Ms. Wallace?

A. It is a medication that I will consider often in the cases that I treat because through the years I had developed

experience in utilizing it and determining its efficacy before Paliperidone came on the market, but the answer to your question is yes.

Q. All right. So is it your professional medical opinion then for Ms. Wallace that Paliperidone would be more effective, as well as have a less instance of side effect treatment than Risperdal?

A. And with your permission I'm going to add this answer for full clarity. If I provided a prescription with Risperdal versus Paliperidone, both are considered capable of achieving improvement in the symptoms so that Dr. Correa could potentially end up determining that competency is restored. The distinction has to do primarily with the side effects because patients with delusional disorder are notoriously hypervigilant and resistant and hypersensitive to the outset of side effects, often to the point of embellishing them. And it is side effects that are often the rate-limiting step for a doctor to be able to prescribe a sufficient dose for a sufficient period of time for the medication to be effective.

So I am choosing and recommending Paliperidone in order to have the best chance to avoid side effects and avoid arising any further resistance in the patient, not only Ms. Wallace, but anyone diagnosed with delusional disorder, to improve the chances of determining the dose that is effective for her and avoiding the introduction of problematic side effects, more

problematic for her because of her hypervigilance secondary to the disorder.

Q. And what --

A. I apologize for the long answer.

Q. No, no, I appreciate the answer. You're the witness, not me, so thank you.

What is the dosage of Paliperidone that you are proposing and recommending?

A. The standard recommended treatment process to introduce injections of Paliperidone are an initial injection of 234 milligrams followed one week later by an additional injection of 154 milligrams. Thereafter -- so those two initial injections are known as loading doses in order to start creating a concentration of the medication in the blood stream and then in the brain where we want it to be effective. Once you introduce those two doses, the follow-up treatment with Paliperidone is one monthly injection of 117 milligrams on a monthly basis.

Now, I would add that there are adjustments that can be made to that protocol if the particular patient being treated is showing a lack of response. There have been some patients, for instance, that have received higher doses than the 117 milligrams a month in order to seek response because the way that each individual metabolizes the medication may have an effect on how effective that particular dose can be. So I

outlined for you the standard recommended protocol for Paliperidone by injection.

Q. And is that the -- that standard recommended treatment, is that the treatment that you are recommending and believe is appropriate for Ms. Wallace based on your evaluation of her and your professional medical opinion?

A. Yes, sir, it is.

Q. If we talk -- you talked about Risperdal before.

Just for comparison's sake, does that have to be injected less or more frequently than Paliperidone?

A. That's another significant consideration in that the standard recommended treatment process with long-acting injected Risperdal is every two weeks, which is another barrier towards anyone that is hypervigilant towards treatment.

Q. All right. So just so I understand, with Risperdal, the regular dosage would be every two weeks. With Paliperidone, it's every month after the loading doses. Have I summarized that right?

A. You have, yes, sir.

Q. Thank you.

If Ms. Wallace agreed to take these medications herself, could it be done orally?

A. Yes, sir.

Q. Has she been encouraged by the FMC Carswell medical staff, including by yourself, to take these medications, that is

Paliperidone, voluntarily?

A. Not only have -- has she been educated, it's often very confusing and overwhelming for a patient going through a forensic evaluation to appreciate the differences between a psychologist's and psychiatrist's role in this process. So I can testify that I have been very detailed and very careful in presenting not only to this inmate, which is our focus of attention, but to all the treatment inmates that come before me, to help them understand my role, to help them understand to the capacity that they have the reason that I'm recommending medication, the diagnosis, the purpose of the medication to alleviate symptoms in their case for restoration, only to the degree that they will then be able to understand court proceedings and participate with their attorney in their defense, which is to say not necessarily for any kind of cure and not necessarily for the resolution of symptoms completely.

So often times, in providing them with the details and helping them be educated as to what their choices are for voluntary consent, that has proven effective in other cases in inmates choosing to consent voluntarily even in the context of the legal proceeding and the restoration process. So I want the Court to know that Ms. Wallace has been afforded all of that information for her to consider and utilize any capacity she has for voluntary consent of medical treatment.

Q. Have you -- and I take it she has declined to voluntarily

take the prescribed medication, is that correct?

A. She has declined on more than one occasion, yes, sir.

Q. You say on more than one occasion.

In the lead up to this hearing, within the last week or so, did you, in fact, go to Ms. Wallace again to try to again convince her that she should voluntarily take these medications?

A. I wouldn't say to convince her, but to confirm that she understood the opportunity to consider voluntary treatment. The answer is, yes, I did.

Q. And what was her response?

A. It's important to clarify for the Court's consideration that I found her to be less defensive and less hypervigilant when I met with her and presented her options the first time, whereas the more recent contact with her I could tell the difference, as is common with delusional disorder patients, that she had integrated me into her beliefs of being persecuted. As a result -- and the way that I could tell is because she refused to remain for the entire examination and was so upset at my trying to engage her in a treatment discussion that she said, "I'm not going to talk to you anymore," got up from the chair, and bolted from the nurse's station where I was conducting the examination.

Q. Okay. Dr. Silvas, in order for antipsychotic medication such as Paliperidone to work, is it necessary that the delusional disorder disappear completely?

A. That's the reason why I made reference to the specific indication and outcome that we're interested in for restoration because that's different than, perhaps, the indications and outcomes in other cases. So we're talking about how the delusional disorder symptoms interfere with that particular patient's capacity to make life decisions.

Q. Dr. Silvas, we talked a little bit before during Dr. Correa's testimony about a *Harper* hearing, that administrative hearing in November of 2021 regarding Ms. Wallace.

Were you also present for that hearing?

A. Yes, I was.

Q. And did you also testify at that hearing?

A. I did.

Q. Did you also see a copy of Government's Exhibit 6 before you came in here today that on page three has a section that summarizes your testimony from that hearing?

A. Yes, sir, I have it before me.

Q. All right. And, in fact, is that section at the top of page three on Government's Exhibit 6 an accurate summary of your testimony from that hearing?

A. Yes, it is.

Q. And furthermore, is that testimony consistent with and somewhat duplicative of what is contained in your report, Government Exhibit 5?

A. It is.

Q. Okay. Is it fair to say that the result of this hearing was that the hearing psychiatrist concurred with both your assessment and Dr. Correa's assessment that Ms. Wallace would not present a danger to herself or others under *Harper,* but that if she were to be medicated, the Court would have to go through a *Sell* hearing and analysis?

A. Yes, sir.

Q. All right. And is that just another way of saying the only appropriate way to medicate her would be for purposes of restoring competency under the *Sell* factors?

A. Yes, sir.

Q. All right. Dr. Silvas, in your professional medical opinion, is there a substantial likelihood that the antipsychotic medication you've recommended for Ms. Wallace, that is the Paliperidone in the doses you've described, will be successful in restoring Ms. Wallace to competency so that she could proceed in these proceedings?

A. Yes.

Q. What does substantial probability mean to you? Can you define or quantify that so the Court can better understand?

A. The first thing that I will say, as I had said earlier in my testimony, is that delusional disorder is known to be a very difficult-to-treat psychiatric condition. And the reason that it's difficult to treat is because of how the patient integrates their false beliefs in conjunction with their particular

personality style and their life experience. And since personality is a lifelong pattern of how a person lives their life and makes their decisions, I always make it a point to bring it to the Court's attention how personality can interfere with it because it's a constant lifelong characteristic and combined with the particular false beliefs -- because the medication is not going to have any impact on the personality. So we're talking about the biochemistry in the brain associated with the thinking process leading to the delusional beliefs that responds to the medication treatment, and that's the component that underscores my recommendation that she is likely to respond.

All right. So if delusional treatment [sic] is difficult to treat -- if you look at the psychiatric literature, you will find very few studies that have looked at treatment response for delusional disorder because you can't get patients to want to participate in the studies voluntarily. Therefore, number one, at Federal Medical Center Butner, a study was conducted some years ago that was able to get participation by inmates diagnosed with delusional disorder to determine response rate. That study is often referred to because there's so few studies. And in that study, the response rate was at 70 percent. And so 70 percent is commonly the response rate that's referred to when you have an involuntarily individual receiving treatment.

Q. And do you concur with the findings of that Butner report

as to the substantial likelihood that prescribing this medication to Ms. Wallace is substantially likely to restore her to competency?

A. To give a complete answer, over the scope of my career -- when I trained as a psychiatrist, my professors warned me and cautioned me that at that time there was no treatment effective for delusional disorder. Through the intervening years of the science of medication making improvements, there are now medications that are effective, including Paliperidone, in treating delusional disorder.

The one thing that I also wanted to mention is, okay, if you have a limited number of cases for delusional disorder to show efficacy, is that all you have? As Dr. Correa had mentioned in the scope of psychotic disorders, schizophrenics also experience delusions. And it is available through studies to show that the delusions suffered by people diagnosed with schizophrenia do respond, so that's the other major area that shows the efficacy of antipsychotic medication to alleviate the intrusive characteristics of delusions.

Q. All right. So I just want to make sure that I understand. It is your professional medical opinion that there's a substantial likelihood that by Ms. Wallace taking the prescribed and recommended doses of Paliperidone, that it's substantially likely that she would be restored to competency, fair statement?

A. Yes.

Q. And that opinion is based not only on your training and experience, but your interactions personally with Ms. Wallace, is that also fair?

A. Yes, sir.

Q. Would Ms. Wallace's taking Paliperidone impair her ability to assist in her own defense of this case?

A. The reason that I recommend Paliperidone, as I've already stated, is our best opportunity to avoid side effects. But that doesn't guarantee being able to avoid all side effects. It is a standard of care to anticipate some degree of side effects being reported or observed in any particular patient. But the side effects that I'm referring to, such as the onset of a mild tremor, for instance as one example, are not likely to be so severe or persist as to interfere with the competency that is restored.

Q. So you mentioned side effects. Let's talk about side effects.

What is your opinion on whether Paliperidone might have negative side effects by someone who uses it?

A. It is likely that any patient that I prescribe Paliperidone will report side effects. It is even more likely if the patient is diagnosed with delusional disorder that they will report side effects. So that piece of clinical work has to do with, number one, determining the validity of the report, and then determining whether there is a clinical association with the

medication being the cause, and then thirdly, making a determination as to whether there's any additional treatment that is necessary to alleviate the side effects.

I will restate that as follows: It is common when antipsychotics are prescribed to also find indication to prescribe anti-side effect medication. Another reason for recommending Paliperidone to the Court is because as difficult as it is to get an individual to accept so-to-speak involuntary treatment, I don't want to also face the additional complication of needing to prescribe side effect medication unless I have no choice.

Q. Can you predict the likelihood of side effects occurring in Ms. Wallace from Paliperidone or the severity of any side effects?

A. The prognosis for the patient with delusional disorder reporting side effects is 100 percent.

Q. Explain.

A. I don't think -- I don't think that that can be avoided, but the likelihood of any reported side effects being severe is very low. To be more specific, likely less than ten percent.

Q. All right. So let's talk a little bit about that. You -- I apologize for the fire trucks going by outside.

You mentioned before that Paliperidone is what you considered a second generation antipsychotic. Is one of the features of the second generation antipsychotics that they have

better tolerability and less side effects than their predecessors, the first generation antipsychotics?

A. Very definitely. And that is the primary reason why the treatment of psychotic disorders has become so much easier for so many more patients to accept, even on a voluntary basis.

Q. And if someone at FMC Carswell, and specifically Ms. Wallace, is being given Paliperidone, will she be continually monitored to see if there are any side effects?

A. Yes, since she is housed on an inpatient mental health unit, it's important to note that the supervision by mental health nurses and correctional staff is 24 hours a day, seven days a week.

Q. If side effects were to be shown in Ms. Wallace, is FMC Carswell equipped to manage them?

A. Yes.

Q. What are some of the more -- you mentioned minor side effects such as tremors.

What are some of the more serious side effects that are possible -- possible by someone who's given Paliperidone?

A. The most serious side effects that are possible and need to be considered as possibilities with any antipsychotic medication, one is known as neuroleptic malignant syndrome, NMS, which is basically an allergy reaction to the medication that would result in an elevation in the individual's body temperature, instability in the individual's blood pressure, and

physical symptoms of very severe muscular rigidity, so severe that the rigidity is physically uncomfortable. And it is considered an emergent medical condition that requires emergent care. So it's important to note that, but also important to note that the risk of neuroleptic malignant syndrome is very rare with the second generation antipsychotics.

The other primary concern of serious side effects is known as tardive, T-A-R-D-I-V-E, dyskinesia, D-Y-S-K-I-N-E-S-I-A, which is a reaction to long-term treatment with antipsychotics where the body, the brain, and nervous system begin to lose the capacity for voluntary motor movement. That was a particular concern with patients that were treated over many years in state hospitals with the first generation antipsychotics and has not been a problem of anything but rare concern. I've never had it occur to any of my patients in the course of the prescriptions that I have written.

Q. All right. So on the tardive dyskinesia condition, if I understand you right, in 40 years of prescribing antipsychotic medications, you've never seen it occur in your patients, is that correct?

A. Not correct. I've never seen it occur with the second generation antipsychotics. I did have to treat it in the first generation treatment with patients.

Q. Thank you.

And is that an important factor to you in recommending this

medication, Paliperidone, as a second generation antipsychotic in terms of your professional opinion in weighing the benefits versus the risks in recommending this medication for Ms. Wallace?

A. It is. And I would add, so that the Court is aware, my tolerance for introducing side effects in my patients with prescriptions that I write is very high, primarily because before I worked in the corrections area, I was trained and practiced as a child psychiatrist. And that experience makes a treating psychiatrist exquisitely sensitive to introducing side effects to children and adolescents, and I carry that in my clinical assessment into my current work with adults.

Q. Let me just make sure I understand that correct, Dr. Silvas.

So you said your tolerance for side effects is very high?

A. I'm sorry, it is low for introducing them --

Q. Okay.

A. -- so -- meaning I want to do everything I can to avoid them.

Q. All right. Your sensitivity towards them is very high, your tolerance for them is very low, is that fair?

A. Thank you for the clarification. That is correct.

Q. All right. I understand.

In terms of the second generation antipsychotic medications, does the time -- the amount of time that the

individual such as Ms. Wallace would be taking that medication as it relates to the risk of a serious side effect like tardive dyskinesia, is that relevant at all in your analysis?

A. It is because the history with tardive dyskinesia and its onset is, as I said, most commonly related to those individuals that are still treated at times with first generation antipsychotics, and the knowledge that the onset of tardive dyskinesia is to be expected only if an individual really has received constant ongoing treatment over at least one year period of time. That had been the usual pattern of onset if it emerged at all.

Q. And in general, and based on your training and experience, how long do you think it would take for you to see some type of a reaction or a positive change in Ms. Wallace from taking this mediation? Or maybe a better way for me to ask that question is: Based on your training and experience, how long does it take for Paliperidone to be effective in a person who's taking it?

A. My standard recommendation in previous testimonies of this sort to the Court was to anticipate a timeframe of response of three to six months. The additional research that I have come across with Paliperidone is indicating that Paliperidone has an efficacy that can be found in patients as quickly as one week after the initial injection, which was stunning for me to find out. I've never seen that kind of response with any other

antipsychotic medication.

Q. In any event, whether a week or three to six months, is that far less than the approximately one year or so period of time that it would generally take for someone to show tardive dyskinesia even in the unlikely event that they develop that as a side effect?

A. Yes. And the reason that I have made the recommendation as long as six months has primarily to do with the treatment process of dealing with side effects, having to make dose adjustments, potentially having to change to another medication, so that allows me the time to do all of the necessary treatment adjustments for the purpose of restoration.

Q. Dr. Silvas, in some cases more generally --

THE COURT: Mr. Eldridge, you froze again.

MR. ELDRIDGE: Oops. Yep, I just got a message.

THE COURT: We can hear you now. So you're going to have to start that question all over again.

MR. ELDRIDGE: No problem. I can't see everybody, but that's okay with me. As long as you guys can hear and see me, I'll keep going.

THE COURT: We can.

Q. So, Dr. Silvas, in some cases more generally, do the risks of taking medications sometimes outweigh the benefits to the patients?

A. Yes.

Q. And have you come to that conclusion in other cases and therefore decided against recommending medications?
A. Yes.
Q. What about in this case, is it your opinion that the risks of taking Paliperidone for Ms. Wallace outweigh the potential benefits in restoring her to competency?
A. By virtue of review of the medical record, I did not identify any contraindications to recommending treatment that would be an unacceptable risk.
Q. So is the -- in your medical opinion, is the treatment you're recommending, that is taking Paliperidone, necessary and appropriate to restore Ms. Wallace to competency?
A. Yes.
Q. Is there a less intrusive treatment that would be practical or workable based on your training, your experience, your dealing with Ms. Wallace, and in reviewing her records that would be practical or workable to restore Ms. Wallace to competency?
A. Well, there is a treatment option that is workable because it's considered a standard of care in the psychological toolbox, but in terms of restoration of competency in a delusional patient not practical.
Q. And what is that treatment?
A. Cognitive behavioral therapy is considered an effective standard of care in the psychologic realm for psychotic

disorders and delusional disorders if the involved patient is willing to engage and participate in the treatment, which is not the case here.

Q. Okay. So it's your opinion that that treatment is not workable for Ms. Wallace, is that fair?

A. Well, it can be offered and I don't -- I'm not sure -- Dr. Correa would have to say whether any aspect of cognitive intervention of that side -- that sort has been tried, I don't know, but I can certainly say that the practical aspect of that treatment when a patient is resistant to even considering having a disorder is -- makes it out of the question.

Q. Okay. And your view is Ms. Wallace is resistant to such thoughts or -- I think it was described before that she lacks insight into her condition, is that fair?

A. She lacks insight and she is very rigid and resistant to rational recommendations.

Q. Is the treatment that you're recommending, that is the Paliperidone in the doses that you've discussed today, medically appropriate for Ms. Wallace?

A. They are a standard of care and are medically appropriate, yes, sir.

Q. Is it your testimony that there would be little to no chance of restoring Ms. Wallace to competency in a reasonable amount of time without her taking antipsychotic medication?

A. Yes.

Q. And is it your testimony that there is a substantial likelihood, I think you said over 70 percent in the Butner study, of restoring her to competency with the regimen of Paliperidone that you're recommending?
A. Yes.
Q. Given your training and experience, would you be recommending this medication for Ms. Wallace if you didn't believe it had a substantial likelihood of restoring her to competency?
A. No, because I'm not going to expose a patient under my care to unnecessary side effects if there's no benefit to be gained.
Q. And, Dr. Silvas, given your training and experience, would you be recommending this medication to the Court for Ms. Wallace if you believed that the risks in her taking it were greater than the benefits of her taking it to restore her to competency?
A. No.
Q. Thank you.
MR. ELDRIDGE: Judge, those are my questions.
THE COURT: All right. Thank you, Mr. Eldridge.
Mr. LaRose?
MR. LAROSE: Thank you.
CROSS EXAMINATION BY MR. LAROSE:
Q. Dr. Silvas, you said at one point, I think earlier on in the treatment process, that you explained and tried to provide education to Ms. Wallace in order to obtain her voluntary

consent as to what the medication was and what it would do, is that right?

A. Yes, sir.

Q. And did you feel that when you were talking to her she understood your explanation and understood what you were proposing to her?

A. Yes, sir. As was reenforced by the patient to me that she understood by her response the reason she didn't need the treatment that I was recommended -- recommending is because she did not believe that she had any form of mental illness.

Q. And when she was advised, I think it was, approximately a week ago once again of the request for her to take the medication and you said that she presented in a more defensive posture towards yourself at this point in time, has she been made aware that without her consent she may be forced to take the medication?

A. Yes, sir. I have received an example of her outrage when I began to discuss that outcome with her if she did not wish to consider voluntary treatment, yes.

Q. And in what manner did she express her opposition to you?

A. She yelled, "I am not going to talk to you anymore," and bolted from the room.

Q. Okay. You talked about the necessity to do this by injection based upon her reluctance to take it. I guess my question is just if this medication is able to be administered

orally, how often does the patient have to take it as opposed to the monthly injection?

A. For the same medication, Paliperidone, to be effective for the purpose of restoration of competency, the individual would need to accept oral medication on a daily basis.

Q. Okay. And you said that I think it can be three to six months for the medication generally to work, but there may be results from this medication within as soon as a week after it has begun to be administered, is that correct?

A. I found a study that provided that information, yes, sir. That is correct.

Q. So let me ask you this: If she remains at Carswell and you begin providing her with this medication by injection, at what point or at what intervals is she going to be reassessed to determine whether it's effective and she has reached a level of competency that would be noticed to court?

A. That is a two component answer as follows: The standard of care for follow-up with me where I will be monitoring for the noted side effects is every two to four weeks. I am not able to state how often Dr. Correa will meet once medication, if approved, is initiated. And the reason that's important is because it is the psychologist who will make the determination if there is a notable response of restoration and not the treating psychiatrist.

Q. Okay. So I guess that was my question then. So that'll --

that determination is bifurcated, you just follow through with the administration of the medicine and what the side effects are and how that is working out, and then the psychologist continues to make the competency determinations?

A. With the additional information that I do have the responsibility to keep the psychologist informed and apprized if I encounter any side effects or any barriers to treatment. Because the standard of care that we have agreed upon in the past, the courts would allow me to proceed with making changes in the medication without informing the court if it was medically appropriate and necessary to proceed, and that's no longer the case. Now, the courts require very specific treatment plans, as has been presented in this case, and if there is a problem where I clinically determine that proceeding with treatment with Paliperidone is no longer recommended, I need to inform Dr. Correa so she can inform the court, and then determination and guidance be received on how to proceed.

Q. If the determination is made that the medication is suitable for her and is improving her situation, would she -- would it be necessary for her to remain on it indefinitely?

A. That's a very pertinent question as follows: I also make sure that I inform a patient who may be recommended for involuntary antipsychotic medication by injection that the course of treatment is only to sustain competency during the court process. Once that is completed, it is common for the

individual to have the option to choose whether they want to continue the treatment or not.

That would introduce as follows: The possibility that if they were sentenced, they would begin their sentence, if they've chosen to discontinue the medication, without involuntary treatment. That, of course, introduces the risk of relapse. And then if the inmate who's sentenced at that time deteriorates to the point that psychiatric treatment involuntarily is again indicated, we have to go through an entire separate process to introduce involuntary medication if consent has not been obtained.

Q. Is there a general timeframe in which a determination is made whether this medication is effective or whether it should be discontinued?

A. No, sir, there's not a general timeframe. That is based on the individual response of the patient.

Q. Okay. And just back to the dosage for a moment.

If it's found to be effective, would it continue to be administered on a one-month basis through the court process then, through any trial or sentencing?

A. Yes.

Q. Okay. If the patient is taken off of the medication either because it's determined to not be effective or it reaches a point where they're allowed to voluntarily terminate the medication, are there any withdrawal symptoms that the patient

would experience?
A. Withdrawal symptoms are unlikely, understanding that the timeframe for the body to clear the medication and metabolize it is five to seven days, but not likely to be associated with this medication to have side effects.
Q. Okay. Thank you.
MR. LAROSE: I have nothing further.
THE COURT: All right. Mr. Eldridge, anything else for this witness?
MR. ELDRIDGE: No, thank you, your Honor.
THE COURT: All right. Do you have any other witnesses then, Mr. Eldridge?
MR. ELDRIDGE: No, your Honor.
THE COURT: All right. Mr. LaRose, are you going to call anybody?
MR. LAROSE: I am not, Judge.
THE COURT: All right. Then I think we are done with -- well, I guess I'll ask you both if you want to make a brief closing statement, but I'm also going to direct that you submit briefs on proposed findings of fact and conclusions of law. So if you'd like to make a short closing statement now, I'll permit that, Mr. Eldridge.
MR. ELDRIDGE: No, thank you, Judge. I'll be happy to order the transcript of the proceedings and provide a written submission as the Court's requested.

THE COURT: All right. Mr. LaRose?

MR. LAROSE: I will waive an oral statement and reserve for the written response.

THE COURT: Okay. All right. So let's go off the record for a moment.

(Whereupon, a discussion was held off the record. Time noted: 1:48 p.m. to 1:50 p.m.)

THE COURT: Let's go back on the record.

All right. So counsel is going to -- counsel for the government is going to request a copy of the transcript and the court reporter has indicated she could probably get that done by the end of the week, but we'll give her a little breathing room. If you get it done by Monday, Ms. Cavanaugh, that would very helpful.

All right. And then I'll direct that closing briefs be filed by April 29th.

MR. ELDRIDGE: Yes, your Honor.

THE COURT: All right. If something, you know, changes in your schedule, your trial goes longer Mr. LaRose, or something else, if you need more time, put a letter on the docket before April 29th and let me know --

MR. LAROSE: Okay.

THE COURT: -- and I'll make a further directive.

But I'm looking for proposed findings of fact and conclusions of law in your closing briefs. Okay?

MR. ELDRIDGE: Understood, your Honor.

MR. LAROSE: Yes, your Honor.

THE COURT: All right. I think that wraps it up right now. So I'm going to obviously reserve decision until I see your closing briefs and we'll go from there.

In the meantime, Ms. Wallace is to stay where she is, you can keep monitoring that she's getting there. All right?

All right. Anybody -- anything either counsel wants to state on the record at this time? Have I covered everything or did I miss anything, let me put it that way.

Mr. Eldridge?

MR. ELDRIDGE: Nothing from the government, Judge. Thank you.

THE COURT: All right. Mr. LaRose, anything else on behalf of the defendant?

MR. LAROSE: No, nothing further. Thank you.

THE COURT: All right then. I think we are concluded then. Thank you to both doctors there for your testimony today.

MR. ELDRIDGE: Yes, thank you.

DR. SILVAS: You're welcome, your Honor.

MR. ELDRIDGE: Thank you, Dr. Silvas. Thank you, Dr. Correa. And thank you, your Honor.

THE COURT: All right, everybody. Have a good day and stay well.

(Time noted: 1:52 p.m.)

CERTIFICATE OF OFFICIAL REPORTER

I, HANNAH F. CAVANAUGH, RPR, CRR, CSR, NYACR, NYRCR, Official U.S. Court Reporter, in and for the United States District Court for the Northern District of New York, DO HEREBY CERTIFY that I transcribed the foregoing proceedings from a digital recording, and that the foregoing is a true and correct transcript thereof.

Dated this 9th day of April, 2022.

s/ Hannah F. Cavanaugh

HANNAH F. CAVANAUGH, RPR, CRR, CSR, NYACR, NYRCR
Official U.S. Court Reporter